PATIENT LAST NAME: _____ PATIENT FIRST NAME: _____

Please complete all information – check if you have / had the items listed below

DENTAL HISTORY

Reason for today's visit: _____ **Date of last dental visit:** _____

Former Dentist: _____ **Date of Last Dental X-rays:** _____

___ Bad Breath
___ Dry mouth
___ Burning sensation on tongue
___ Lip / cheek biting
___ Smoking (pipe, cigar, cigarette, vape)
___ Smokeless tobacco
___ Growths in mouth / blisters
___ Loose teeth / broken filings
___ Gums- tender, swollen or bleeding
___ Clench or grind teeth
___ Food collection between teeth
___ Head, neck, jaw pain
___ Mouth breathing
___ Periodontal / gum treatment
___ Sensitivity: pressure, cold, sweets, heat
___ Prolonged bleeding after surgery

Have you ever had an allergic reaction to Novacaine, local or general anesthetics?
___ Yes ___ No
If yes, please explain:
_____

Have you ever had trouble from previous dental care?
___ Yes ___ No
If yes, please explain:
_____

MEDICAL HISTORY

Primary Care Physician's Name: _____ **Date of last visit:** _____

Physician's Address: _____ **Physician's Telephone #: (____)** _____

Have you received an artificial joint or heart valve? ___ Yes ___ No If Yes, provide approximate date(s): _____

Have you had any other surgery in the last year? ___ Yes ___ No If Yes, list: _____

Have you been hospitalized in last 6 months? ___ Yes ___ No If Yes, explain: _____

Have you ever had a blood transfusion? ___ Yes ___ No If Yes, give approximate date (s): _____

Do you use an Inhaler? ___ Yes ___No If Yes, date of last episode: _____

Women, are you pregnant? ___ Yes ___ No Due Date: _____ **Nursing? ___ Yes ___ No**

___ Allergies, hay fever, sinusitis
___ Anemia
___ Arthritis, Rheumatism
___ Asthma, Emphysema, Shortness of breath
___ Other Respiratory disease
___ Blood disease, clotting disorder
___ Circulatory problems
___ Cancer
___ Chemotherapy / radiation treatments
___ Chemical dependency
___ Cortisone / other steroid treatments
___ Diabetes
___ Epilepsy/Fainting
___ Glaucoma
___ Headaches
___ Low or High blood pressure/ heart problems
___ Pacemaker
___ Stroke
___ Swelling of feet / ankles
___ Osteoporosis / weak bones
___ Acid reflux / GERD
___ Immune deficiency
___ Rheumatic or Scarlet Fever
___ Sickle Cell Anemia
___ Skin rash / disease
___ Slow healing wounds
___ Thyroid problems
___ Ulcer
___ Venereal disease
___ HIV
___ Hepatitis A, B or C
___ Unexplained weight loss

Are you currently taking any of the following?
___ Aspirin
___ Blood thinners
___ Antibiotics or sulfa drugs
___ High blood pressure medicine
___ Antidepressants or tranquilizers
___ Insulin or other diabetes drugs
___ Nitroglycerin
___ Cortisone / other steroids
___ Osteoporosis medicine
___ Prescription pain medicine
___ Other / supplements:
_____
_____
_____

Are you allergic / had adverse reactions to:
___ Latex
___ Penicillin or other antibiotics
___ Local anesthetics
___ Codeine / other narcotics / any pain medications
___ Sulfa drugs
___ Aspirin
___ Other: _____

CERTIFICATION OF INFORMATION PROVIDED

I have read and answered the above questions to the best of my knowledge.

Patient / Guardian Signature: _____ Date: _____

Reviewed by: _____ Date: _____